



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ELITE HEALTHCARE FORT WORTH  
SUITE 108  
1100 BRIDGEWOOD DRIVE  
FORT WORTH TEXAS 76112

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **MFDR Tracking Number**

M4-13-3073-01

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Date Received**

JULY 22, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Dr. Lopez has furnished several key components for this service, on the soap note and as well as the letter. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full. "

**Amount in Dispute:** \$262.90

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "99204 was reduced after review of the bill and medical record as this service is best described by code 99204 and submitted documentation did not meet the key components required for CPT code 99204."

**Response Submitted by:** Thornton, Beichlin, Segrato, Reynolds & Guerra, L.C.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
APRIL 16, 2013	99204	\$262.90	\$0

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-150 Payer deems the information submitted does not support this level of service.
- \*15 – (150) Payer deems the information submitted does not support this level of service .

### **Issues**

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99204 is:

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

- Documentation of the Comprehensive History
    - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed three elements. This component was not met.
    - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least 10 organ systems must be reviewed. Documentation found listed two systems, this component was not met.
    - Past Family, and/or Social History (PFSH) requires a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed one area. This component was not met.
  - Documentation of a Comprehensive Examination:
    - Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed two body/organ systems. This component was not met.
2. For the reasons stated above, the services in dispute are not eligible for payment pursuant to 28 TAC §134.203 (c).

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	September 27, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**